STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-02763

1. DECEASED NAME (TYPE OR PRINT): FIRST Wallace MIDDLE Murell LAST Adkins

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 1 DAY 7 YEAR 19 75 — 2b. HOUR 12:30 P.M.

3. SEX: male — 4. RACE: white — 5. DATE OF BIRTH: MONTH 8 DAY 26 YEAR 24 — 6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 7 YEAR 19 75 — 2d. HOUR 12:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester County MD.

10. CITY OR TOWN OF DEATH: Ocean City — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrician Helper — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Worcester — 13c. CITY OR TOWN: Berlin — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Libertytown Road

14. FATHER'S NAME: FIRST Ephriam MIDDLE LAST Adkins

15. MOTHER'S MAIDEN NAME: FIRST Marjory MIDDLE Bessie LAST Timmons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 200-18-4884

17. INFORMANT ADDRESS: Norman Aydelotte Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetes mellitus

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described obave, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED 1--7--75

EXAMINER'S NAME (TYPE OR PRINT): Francis J. Townsend Jr., M.D. ADDRESS 1001 Phila Ave Ocean City, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE 1/10/75 — 23c. NAME OF CEMETERY OR CREMATORY: RIVERSIDE — 23d. LOCATION CITY OR TOWN: BERLIN COUNTY: Wor. STATE: MD.

24. FUNERAL DIRECTOR NAME: Amos A. Burbage ADDRESS: Berlin Md. — 25a. DATE REC'D. BY REGISTRAR: JAN 13 1975 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M 1/73
(VR A15 ME (5))

12-05103

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-02764

1. DECEASED NAME (TYPE OR PRINT) FIRST: LOSSIE MIDDLE: EDNA LAST: ARVEY				2a. DATE OF DEATH MONTH DAY YEAR: January 27, 1975	2b. HOUR: 7:30 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: September 17, 1891	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.		
10. CITY OR TOWN OF DEATH: Stockton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: -----	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	211 Record Street

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
John / Henry / Gravenor	Louise / Tyre	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 219-34-3810-1
17. INFORMANT (daughter) ADDRESS: 617½ Newton Ave.	Mrs. Florence Rogers, Oaklyn, N. J.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	4124	
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebro-Vascular Accident	
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Cardiovascular Disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5-22, 19 73, to 1-27, 19 75, that (I) (we) last saw the deceased alive on 1 27 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J. G. Santiano M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	1/28/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. J. G. Santiano	1402 Market St., Pocomoke, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/29/75	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, Salisbury, Maryland	FEB 05 1975	

DHMH-1660M 1/73
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

FOR STATE HEALTH DEPT.

Item 5 Film G480
2/4/75 sy

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-02765

1. DECEASED-NAME (Type or Print)	First: Fred	Middle: Douglas	Last: Boggs	2a. DATE KNOWN OF DEATH ESTIMATED	Month: Jan.	Day: 17	Year: 1975	2b. HOUR: 11 AM
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: Mar. 23, 1947	6. AGE (In years last birthday): 27 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month JAN Day 17 Year 1975	2d. HOUR: 11 PM
7a. BIRTHPLACE (State or foreign country): Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.				
10. CITY OR TOWN OF DEATH: Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Groom	12b. KIND OF BUSINESS OR INDUSTRY: Horse Races				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER			
14. FATHER'S NAME: First Fletcher Middle Lee Last Dix	15. MOTHER'S MAIDEN NAME: First Ernestine Middle Boggs Last Kellam						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Ernestine Boggs Kellam	ADDRESS: Tasley Va				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE HEAD INJURY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF
(b) ACCIDENT (CAR)
DUE TO, OR AS A CONSEQUENCE OF
(c)

8159

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	11 A.M. 1-17 1975	AUTO HIT TREE AFTER SLIDING

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	ROUTE 113		SNOW HILL	WORCESTER	Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Dorothy C. Holzworth M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 1-22-75

EXAMINER'S NAME (Type) Dorothy C. Holzworth, M. D., ADDRESS (Street, City, Town, or County) 104 Bay Street, Snow Hill, Md., Worcester Co.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 26, 1975	Family Plot	Tasley Accomack Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Samuel Savage - New Church, Va	JAN 28 1975	Sidney [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with [illegible] PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-02775

1. DECEASED NAME (TYPE OR PRINT): Mary Lavina Townsend
2a. DATE OF DEATH: MONTH 1 DAY 21 YEAR 75
2b. HOUR: 6:30 A.M.
3. SEX: female
4. RACE: White
5. DATE OF BIRTH: MONTH 6 DAY 5 YEAR 1883
6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ■ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.
10. CITY OR TOWN OF DEATH: Ocean City
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 206 Philadelphia Ave.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Ocean City
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 206 Philadelphia Ave.

14. FATHER'S NAME: Charles Cropper
15. MOTHER'S MAIDEN NAME: Katherine Gray
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: none
17. INFORMANT: Henrietta Timmons ADDRESS: Ocean City, Md. 100 Talbot St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASCVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: F Townsend Jr. M.D. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1-21-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Francis J. Townsend Jr., M.D.
22e. ADDRESS: 1001 Philadelphia Ave. Ocean City Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 1-23-75
23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
23d. LOCATION CITY OR TOWN: BERLIN COUNTY: WORCESTER STATE: Md.
24. FUNERAL DIRECTOR NAME: Peter Whaley ADDRESS: Selbyville, Del.
25a. DATE REC'D. BY REGISTRAR: JAN 24 1975
25b. REGISTRAR'S SIGNATURE: Sidney H Watson

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1-73
(VR A 15 (4))

1

FOR STATE HEALTH DEPT.

Items 4, 23a through 23d
g479 1/29/75 89

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-02766

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1 and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible] Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removol, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: JOHN	Middle: VINCENT	Last: CATALDI	2a. DATE KNOWN ☐ OF DEATH ESTIMATED ☐ Month: JAN Day: 8 Year: 75	2b. HOUR: 1220 P M	
3. SEX: M	4. RACE: Cau	5. DATE OF BIRTH: 15 FEB 55	6. AGE (In years last birthday): 19 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: Jan Day: 8 Year: 75	2d. HOUR: 1260 P M
7a. BIRTHPLACE (State or foreign country): PENN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WORCESTER Md.		
10. CITY OR TOWN OF DEATH: Whaleyville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RT Box 232	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MARINE	12b. KIND OF BUSINESS OR INDUSTRY: USMC		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENN	13b. COUNTY	13c. CITY OR TOWN: Boothwyn	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last: Joseph R. CATALDI	15. MOTHER'S MAIDEN NAME First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): OCT 73 - present	16b. SOCIAL SECURITY NO.: 185-44-7026	17. INFORMANT: FLIGHT SURGEON	ADDRESS: USMC, MCAS(H) JACKSONVILLE N.C		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple INJURIES FRACTURES + BURNS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO, OR AS A CONSEQUENCE OF
(b): Helicopter CRASH
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☑ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): F. J. Townsend, JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): WORCESTER COUNTY Ocean City Md (County) (State)
22b. DATE SIGNED: JAN 8, 1975

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 1-11-75	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town): Chester Pa	
24. FUNERAL DIRECTOR: Torchet Funeral Chapel	ADDRESS: [illegible]	25a. REC'D BY REGISTRAR DATE: JAN 17 1975	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15ME (5)
10M REV. 1/68

75-02165

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-02767

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1 and 2, be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
8M-1/70

1. DECEASED-NAME (Type or Print)	First: Billy	Middle: T.	Last: Hambrick Jr.	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☑	Month: Jan.	Day: 18	Year: 1975	2b. HOUR: 11:30 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: July 26 1954	6. AGE (In years last birthday): 20 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month Jan. Day 19 Year 1975		2d. HOUR: 6 A M	
7a. BIRTHPLACE (State or foreign country): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.						
10. CITY OR TOWN OF DEATH: Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 208 Walnut St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laber	12b. KIND OF BUSINESS OR INDUSTRY: Timber						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 208 Walnut St.					
14. FATHER'S NAME: First Billy Middle T. Last Hambrick Sr.		15. MOTHER'S MAIDEN NAME: First Barbara Middle — Last Toney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT ADDRESS: Mrs. Barbara Hambrick, Snow Hill, Md.							

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	INTRA ABDOMINAL HEMORRHAGE	@ 30 MIN
DUE TO, OR AS A CONSEQUENCE OF (b)	BULLET WOUND OF ABDOMEN	@ 30 MIN
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

955.4

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
POSSIBLE ALCOHOLISM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural couses ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: J Robt La Mar M.D.

EXAMINER'S NAME (Type): ROBERT C. LA MAR?, M.D. 104 Bay St Snow Hill, Md 21863

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: JAN 19, 1975

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: Jan 20 1975	23c. NAME OF CEMETERY OR CREMATORY: Lobban Funeral Home	23d. LOCATION (City or Town) (County) (State): Aldersan, West Virginia	
24. FUNERAL DIRECTOR: Norman G. Lemmon	ADDRESS: Snow Hill, Md.	25a. REC'D BY REGISTRAR DATE: JAN 22 1975	25b. REGISTRAR'S SIGNATURE: Lindsay L. Linton	

75-02157

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-02768

1. DECEASED-NAME (Type or print): First JAMES Middle I. Last HUDSON
2a. DATE OF DEATH: Month JAN Day 14 Year 1975
2b. HOUR: 7:30 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: JUNE 26, 1886
6. AGE (In years last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: WORCESTER Md.
10. CITY OR TOWN OF DEATH: BERLIN Md RFD
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): AT HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CARPENTER
12b. KIND OF BUSINESS OR INDUSTRY: RETIRED
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: WORCESTER
13c. CITY OR TOWN: BERLIN
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: R.F.D.
14. FATHER'S NAME First FRANK Middle Last HUDSON
15. MOTHER'S MAIDEN NAME First ELIZABETH Middle HALL Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): X
16b. (If yes give war or dates of service): X
16b. SOCIAL SECURITY NO.: 220-10-9905
17. INFORMANT: ANNABELL HUDSON Address: BERLIN Md RFD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
L.B.B.B.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9-13-74, 19__, to 1-14, 19 75, that (I) (we) last saw the deceased alive on 12-18-74 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alfredo B. Fernandez MD DEGREE: MD ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 1-14-75
22d. PHYSICIAN'S NAME (Type): ALFREDO B. FERNANDEZ
22e. ADDRESS: OCEAN CITY BLVD. BERLIN. MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 1-16-75
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. BISHOPVILLE
23d. LOCATION (City or Town) (County) (State): BISHOPVILLE WORCESTER Md
24. FUNERAL DIRECTOR: Miller Whaley ADDRESS: Selbyville, Del.
25a. REC'D BY REGISTRAR DATE: JAN 20 1975
25b. REGISTRAR'S SIGNATURE: Sidney Morton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records, State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

Items 4,7a,7b,8,10,11,12a,13a-13e, 16a-17,23a,23d,24

1 - FOR STATE REGISTRAR 479 1/29/75 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-02769

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR	
MARK	DAVID	LAMASCUS	JAN	8	19 75	2:50	P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
M	Cau	[redacted]				JAN	8	19 75	1:35 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
San Diego Calif	USA		Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Whaleysville	Rt 1 Box 232	USAF	USAF

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
NC		Jacksonville	YES ☐ NO ☒	

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS
yes 1973-1975	238-92-6793	Medical Records of Deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Injuries, Fractures and Burns	INSTANT
DUE TO, OR AS A CONSEQUENCE OF (b)	Helicopter Crash	
DUE TO, OR AS A CONSEQUENCE OF (c)		

8411 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE F.J. Townsend Jr. M.D. TITLE (SPECIFY) Deputy Medical Examiner DATE SIGNED Jan 8, 75

EXAMINER'S NAME (TYPE OR PRINT) F.J. TOWNSEND JR ADDRESS Ocean City, Md 21842

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Removal			Jacksonville N.C.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Torbert F/H Dover Delaware	JAN 17 1975	Sidney H Watson	

75-02169

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Parts 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(S) 8M-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-02770

1. DECEASED-NAME (Type or Print)	First: Christine	Middle: Tull	Last: Lloyd	2a. DATE KNOWN ☑ OF DEATH / ESTIMATED ☐	Month: Jan.	Day: 7	Year: 1975	2b. HOUR: 12:30 PM			
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: Dec. 25, 1891	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: ~~Jan.~~	Day: 7	Year: 1975	2d. HOUR: 1 PM		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.								
10. CITY OR TOWN OF DEATH: Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Stevens St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: Stevens St.							
14. FATHER'S NAME First: John	Middle: W.	Last: Taylor	15. MOTHER'S MAIDEN NAME First: Etta	Middle:	Last: Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212186783	17. INFORMANT ADDRESS: Mrs. Grace Tull, Crisfield, Md.									

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

DUE TO, OR AS A CONSEQUENCE OF

(b): HYPERTENSION — MANY YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c): ASHD — MANY YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Dorothy C. Holzworth M.D.

EXAMINER'S NAME (Type): DOROTHY C. HOLZWORTH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 1-9-75

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY ~~OR CREMATORY~~	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 10, 1975	Hall's Hill	Pocomoke City, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Norman P. Lemmon	Snow Hill, Md.	JAN 14 1975	Sidney H. Horton

75-02770

Item 23a through 23d g479 1/29/75

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-02771

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
GRANVILLE	DEXTER	PULLEN

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH JAN DAY 8 YEAR 19 75 — 2b. HOUR 1230 M

3. SEX: M — 4. RACE: W — 5. DATE OF BIRTH: MONTH 11 DAY 24 YEAR 48 — 6. AGE (IN YEARS LAST BIRTHDAY): 26 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH JAN DAY 8 YEAR 19 75 — 2d. HOUR 1235 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. C.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD

10. CITY OR TOWN OF DEATH: Whiteville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): R F D Box 232

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PILOT

12b. KIND OF BUSINESS OR INDUSTRY: USMC

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: N.C. — 13b. COUNTY: ONSLOW — 13c. CITY OR TOWN: JACKSONVILLE — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS

14. FATHER'S NAME FIRST: CT — MIDDLE: D. — LAST: PULLEN

15. MOTHER'S MAIDEN NAME FIRST — MIDDLE — LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): 10-70 → present

16b. SOCIAL SECURITY NO.: 576-54-1234

17. INFORMANT: Flight Surgeon ADDRESS: USMC, MCAS(H) Jacksonville, N.C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries, Fractures & Burns — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO, OR AS A CONSEQUENCE OF
(b): Helicopter Crash
DUE TO, OR AS A CONSEQUENCE OF
(c):

8411 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☑ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: T.J. Townsend Jr. — TITLE (SPECIFY): M.D. Deputy Medical Examiner Worcester County — DATE SIGNED: Jan 8, 75

EXAMINER'S NAME (TYPE OR PRINT): T. J. Townsend Jr. — ADDRESS: Ocean City, Md 21842

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal — 23b. DATE: 1-13-75 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION CITY OR TOWN: Bangor COUNTY: Maine STATE

24. FUNERAL DIRECTOR NAME: Robert Lund Home — ADDRESS: Dover Del.

25a. DATE REC'D. BY REGISTRAR: JAN 17 1975 — 25b. REGISTRAR'S SIGNATURE: Audrey J. Norton

DHMH-17 20M 1/73
(VR A15 ME (5))

12-05111

Items 23a through 23d g479 1/29/75

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-02772

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
EDWIN	JOHN	RUFF	JAN	6,	75	12:30 P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
M	W	1	8	46	29 YRS.		
2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
	JAN	6	75	12:50 P M			

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
TEXAS	USA		WORCESTER MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Whaleyville	RT BOX 232	PILOT	USMC

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
TEXAS		STEVENSVILLE		

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
E(dwin)	J(ohn)	RUFF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (NAME, RELATIONSHIP, ADDRESS)
YES	4-70- present	516-54-2955	Flight Surg MCAS (H) JACKSON ville N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple INJURIES, FRACTURES + BURNS	INSTANT
DUE TO, OR AS A CONSEQUENCE OF (b)	Helicopter CRASH	
DUE TO, OR AS A CONSEQUENCE OF (c)		

8411 · Conditions, if any, which gave rise to immediate couse (a) stoting the underlying cause lost.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☑ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remoins described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, ond in my opinion death resulted from: Natural couses ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE F.J. Townsend M.D. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED JAN 8, 75

EXAMINER'S NAME (TYPE OR PRINT) F.J. TOWNSEND, JR ADDRESS Worcester County Depot Ocean City, Md 21842

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Removal	1-14-75	Arlington Cem	Arlington Va	

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Tolbert Funeral Home Ocean City	JAN 17 1975	Sidney L. Norton	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

12-05115

Items 23a through 23d g479 1/29/75

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 75-02773

1. DECEASED NAME (TYPE OR PRINT) FIRST: RALPH	MIDDLE: CLAUDE	LAST: SCHLECTIC	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH: JAN	DAY: 8	YEAR: 1975	2b. HOUR: 1:55 PM
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH: 6 DAY: 16 YEAR: 48	6. AGE (IN YEARS LAST BIRTHDAY): 26 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH: JAN DAY: 8 YEAR: 1975	2d. HOUR: 2:25 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENN	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.
10. CITY OR TOWN OF DEATH: Whaleys ville, Md	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RT Box 232	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MARINE	12b. KIND OF BUSINESS OR INDUSTRY: USMC

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
PENN		PERKASIE	YES ☐ NO ☒	

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
RALPH / Schlectic	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
YES	9-69 → present	208-36-0427	FLIGHT SURGEON USMC, MCAS(H) New River, N.C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Mutiple injuries, FRACTURES & BURNS	INSTANT
DUE TO, OR AS A CONSEQUENCE OF (b)	Helicopter CRASH	
DUE TO, OR AS A CONSEQUENCE OF (c)		

8411 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: E J Townsend Jr. M.D. TITLE (SPECIFY): Deputy Worcester County MEDICAL EXAMINER. DATE SIGNED: JAN 8, 75

EXAMINER'S NAME (TYPE OR PRINT): E J Townsend, JR ADDRESS: Ocean City Md 21842

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal	1-11-75		Sellersville Pa

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Torbert Funeral Home Ocean City Md	JAN 17 1975	Sidney R Morton

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M 1/73
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-02774

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) (LAST) WARAWA — MIDDLE — (FIRST) MYKOLA

2a. DATE KNOWN OF DEATH ESTIMATED ☐ MONTH JAN DAY 7 YEAR 19 75 — 2b. HOUR 525P M

3. SEX M — 4. RACE W — 5. DATE OF BIRTH MONTH 05 DAY 09 YEAR 14 — 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH JAN DAY 7 YEAR 19 75 — 2d. HOUR 630P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UKRAINE — 7b. CITIZEN OF WHAT COUNTRY? UKRAINE — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.

10. CITY OR TOWN OF DEATH RZ BERLIN — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence of IWAN BILOUS — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired — 12b. KIND OF BUSINESS OR INDUSTRY —

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md — 13b. COUNTY Somerset — 13c. CITY OR TOWN CRISFIELD — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS 316 Pine St

14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST — 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. 189-28-3053 — 17. INFORMANT ADDRESS IWAN BILOUS RZ Box 134 Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD with Chronic Myocardial INSUFF. — 4 years

DUE TO, OR AS A CONSEQUENCE OF (c)

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural coures ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE F J Townsend Jr — TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER — DATE SIGNED JAN 7, 75

EXAMINER'S NAME (TYPE OR PRINT) F.J. TOWNSEND JR — ADDRESS Ocean City Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — 23b. DATE 1/11/75 — 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN — 23d. LOCATION CITY OR TOWN BERLIN COUNTY Wor. STATE Md

24. FUNERAL DIRECTOR NAME Anna A. Burbage ADDRESS Berlin Md — 25a. DATE REC'D BY REGISTRAR JAN 13 1975 — 25b. REGISTRAR'S SIGNATURE Sidney Horton

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH-17 20M 1/73
(VR AT5 ME (5))